(the C.P.S. meeting being under the Chairmanship of Dr. Ray Lyman Wilbur), and as printed in CALIFORNIA AND WESTERN MEDICINE for July.

It is possible that, had request been made, the A.M.A. Bureau of Medical Economics, also located at 535 North Dearborn Street in Chicago, would have been in position to give the *J.A.M.A.* editor a clearer orientation concerning these matters.

The changes authorized by the C.M.A. House of Delegates in May last, for better administration of C.P.S., rested in considerable part upon information presented by Mr. Little. So that much has already been done to make some of the recommendations effective.

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On Availability of High Quality Medical Service at Low Cost.—In his third paragraph, Dr. Fishbein talks about "trends" and what a medical philospher of long ago said thereon, and then expounds thusly:

"If there were but one way in which the people could secure a high quality of medical service at a low cost, the problem of the medical profession at this time would be exceedingly simple. There are, however, many different approaches to this problem. There is the former technique of the California Physicians' Service and the changed plan. There are similar but in some respects different plans already in effect in other states. There are the techniques now being developed by a variety of private insurance agencies in coöperation with large industries. There is the plan of Mr. Henry Kaiser. There is the possibility of compulsory sickness insurance on a county, a state or a national basis."

Commenting on the above, it may be said that few reasonable people believe that "the problem of the medical profession at this time" *is* simple. Some realistic and thoughtful people within the profession do believe, however, that it *is solvable.* Certainly most human progress is through evolution. Physicians are reluctant to believe that evolution is impossible in the great humanitarian urge of doctors to provide even better medicine to larger numbers of people. Through the use of evolutionary methods, even though some of the experience must be acquired the hard way, through trial and error, the California Medical Association has been making a sincere effort to make available for low income groups, good quality medical care at reasonable cost.

* * *

California Medical Association Has Given Much in Both Thought and Money to Improve Medical Care Facilities.—As should be well known even at A.M.A. headquarters, the members of the California Medical Association, after some years of earnest discussion, and expenditure of from fifty to seventy-five thousand dollars, worked out the statewide prepayment plan now operating as California Physicians' Service. It is the hope of the medical profession of California that as C.P.S. grows in number of members and strength, it will be able to continue to give a high quality of medical service at reasonable cost as provided by the patient's own personal physician, and with maintenance of the principle that medical ethics and standards are strictly the prerogatives of doctors themselves.

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Editor Fishbein's Erroneous Conclusion.—Dr. Fishbein concludes his editorial with this statement: "The most important fact that comes out of Mr. Little's survey is that people in California were not satisfied with the California Physicians' Service up to the time of his survey and that changes seemed to be necessary to satisfy the people. Whether these changes when made will be satisfactory will remain, of course, for time and the California Medical Association to determine."

Fortunately, as regards the point of view of most California physicians, it may be said they do not concur in Dr. Fishbein's pessimistic interpretation of Mr. Little's report, or the implied opinion that California Physicians' Service has failed. Reference to the C.P.S. report in the current issue shows that in the month of October 20,000 new members were added to the roster of beneficiary members, of whom there are now some 103,475, and that C.P.S. as a business organization has now an annual gross income of some $1,500,000. Other reports in recent issues, on the lessons learned in five years of operation, with activities for which, in the beginning, there was practically no actuarial information for guidance, give additional information on the excellent progress that has been made.

Therefore, even though Editor Fishbein seems somewhat downhearted or pessimistic about California Physicians' Service, for that is at least the transient impression given through its perusal—most of the physicians of California take pride in its achievements, and hope its experiences will be of aid not only to the profession of California, but to other State and local medical organizations throughout the United States.

PAY PATIENTS IN COUNTY HOSPITALS OF CALIFORNIA: SOLUTION PROPOSED BY ATTENDING STAFF OF LOS ANGELES COUNTY HOSPITAL

Interesting Article on Los Angeles County Hospital Plan. — CALIFORNIA AND WESTERN MEDICINE, in its issue for September, 1944, on pages 158-159, printed an article, "The Los Angeles County Hospital and the Lanham Act," taken from the *Bulletin of the Los Angeles County Medical Association.* The article is worthy of perusal by all members of the California Medical Association, since the functions of county hospitals in relation to "pay-patients" (non-indigent patients) has been a problem that has received much discussion in the last 25 years or so, by both component county medical societies and the State Association.

Legal Background of County Hospitals.—Before making comment on the Los Angeles plan, it may be well to remind readers of some fundamental legal facts bearing on the question, "Shall non-indigent patients be admitted into county hospitals that are solely supported by tax-payers?"

In California, the 58 constituted counties are legal entities and units of the commonwealth. These counties are governed by Boards of Supervisors, most often consisting of five members. A legal obligation of each Board of Supervisors is the protection of the health and lives of indigent citizens. To care for serious illnesses and injuries of indigent citizens, county hospitals have been established.

For many years, especially in the days when, in legal nomenclature and the press, the "pauper" appellation had not been discarded for the more euphonious term, "indigent," most of the county hospitals limited themselves to service for the penniless group of citizens. During that period the capital outlay in buildings and equipment was not of a kind to be attractive to citizens who could secure the services of a physician in private practice (even though, ofttimes, the physician received little or no actual pay).

However, as time went on, and as communities grew in population, many of the county hospitals likewise increased in size and facilities. In some counties, full time and well-qualified medical personnel was placed in charge. Under these conditions, with up-to-date county hospital buildings and equipment, and improved medical service, a not inconsiderable number of citizens began to clamor for county hospital care. So gradually, in some California counties, the strict limitation that county hospitals should function only for service to indigent citizens broke down.

Solution of the problems related to entrance qualifications for county hospital service has not been easy, because local environments bring different factors into consideration. For instance, in San Francisco County, the Medical Schools of the University of California and Stanford University have special arrangements. In Los Angeles County, the two medical schools work under a different system. In other places, Alameda for instance, and in Sacramento, San Diego and Fresno and other counties, altogether different conditions obtain. Wherefore, it is understandable why no one solution of the pay-patient problem has been found that will answer the needs of each and all.

So much in the way of foreword concerning the new Los Angeles County Hospital plan to have non-indigent patients pay for professional services rendered in the County Hospital, when same have been given by physicians of the attending staff.

* * *

Other Data Concerning the Los Angeles County Hospital.—Leaving out of discussion the smaller counties organized in the gold rush, forty-niner days (one California County—Alpine—well populated in the mining days, now has a total population of about 241 citizens!), let us consider the *Bulletin* article that makes special reference to the Los Angeles County Hospital. The main division of that institution is today one of the largest hospitals in the United States; and in addition to a large full-time medical personnel, has an attending staff of some 600 members who give their services without cost to either the County or patients. The average daily in-patient load is about 2,446, assuredly a large number of patients.

Under wartime and emergency conditions, with private and semi-private hospitals filled to overflowing, it has not been possible in Los Angeles to limit admissions to indigents, or to the closely related group, now-a-days referred to as "medically-indigent" (persons with financial means sufficient to provide food, clothing and housing, but who possess no reserves for care of ill health or injuries).

* * *

How the Attending Staff of the Los Angeles County Hospital Is Attempting to Solve the Problem.—As stated, the 600 members of the Los Angeles County Hospital have been happy to give their gratuitous professional services to the indigent and medically-indigent groups, but the attending physicians and surgeons have long felt it was not fair for a wealthy county, such as Los Angeles, to require them also to give free medical care to citizens who possess financial resources, sufficient to enable them to engage the services of physicians in private practice.

The procedure through which the staff of the Los Angeles County Hospital, the constituted authorities of the institution and the County Board of Supervisors, have attempted to solve this problem can be understood by reading the following excerpts from the article to which reference has been made:

> . . . After studying the matter thoroughly the committee recommended that the hospital administration establish a program whereby fees for hospital care and for medical and surgical services would be collected from this class of non-indigents. It was further recommended that such fees should not be paid to the individual staff physicians rendering the services, but placed in a special research fund to be administered jointly by members of the two medical schools. It was advised that non-members of the staff of the hospital be not permitted to care for patients in the hospital because of administrative difficulties and interference with the program for training medical students, interns and resident physicians. The recommendations of the committee were adopted by the Medical Advisory Board without any dissenting vote. . . .
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> This committee held several meetings and received suggestions from many different sources. Its report was approved by the Medical Advisory Board on June 15, 1944, and the hospital administration was requested to establish the fiscal mechanism for collecting such fees and allocating them to the special committee known as the "Medical Research Fund of the Los Angeles County General Hospital." Dr. Burrell O. Raulston, dean of the University of Southern California School of Medicine, and Dr. W. E. Macpherson, dean of the College of Medical Evangelists, have been named co-chairman of the research committee which will administer the fund.

At the conjoint meeting of the medical and surgical staffs of the General Hospital which was held on Monday, June 26th, Dr. Bayley presented the work of his fee schedule committee with a statement that it had been approved by the Medical Advisory Board. After some discussion, the proposal was unanimously approved by the staff. . . .

THE FEE SCHEDULE:

General Medical Care—$5.00 per day with certain limitations by the hospital management upon this fee when a patient is confined for an unusually long time in the hospital.

Surgical Fee—Surgical and obstetrical procedures are to be classified into major and minor operations, and, in turn, major and minor operations are subdivided into groups A, B, C, and D:

Major Operations		Minor Operations	
A	$250.00	A	$100.00
B	200.00	B	75.00
C	150 00	C	50.00
D	100.00	D	25.00

A special stamp bearing the classification Major or Minor A, B, C, D, will be furnished by the hospital and imprinted upon the operative record of each patient. Following an operation the surgeon in connection with his dictation to the surgical stenographer will merely dictate his classification of procedure; that is, a difficult laparotomy such as gallbladder, resection of stomach or intestinal anastomosis, would be classified as Major A. It is believed that all procedures within the hospital can be appropriately classified in this manner. It is believed that the committee's plan to use this simple classification will be much easier in practical application than a fee schedule. . . .

A few words of comment may be in order concerning the general philosophy underlying this program. There was some thought on the part of the hospital management that the schedule as outlined is too high. The fee schedule committee felt very strongly that this schedule should represent only a reasonable minimum fee for the procedures contemplated. It must be borne in mind that once such a schedule is used it is quite likely to be quoted in court procedure as a basis for establishing the value of medical and surgical services and thus, it should not be too low. It was understood that when such a schedule imposes hardship upon any patient the hospital management will not press for collection. Certainly the rendering of a bill covering medical care will serve the salutary purpose of informing a patient that services of value have been rendered. It is doubtful that legal attempts at collection will be made or would be desirable. . . .

* * *

County Medical Societies Should Keep in Touch with Their County Hospitals.—What has been noted above should be sufficient to lead attending staffs of other county hospitals in California to consider similar lines of procedure. If one County can make arrangements, other counties likewise should have the same legal rgihts.

Other phases of the subject could be discussed, if space were available. This present comment is made to express the hope that county medical societies throughout California will continue to maintain active interest in the manner in which their respective county hospitals carry on their work. The members of County Societies owe much active interest not only to their fellow citizens, but to their profession.

EDITORIAL COMMENT†

HEREDITARY SPERM GROUPS

Applying the common procedure for the demonstration of hereditary blood groups in domestic animals, Snell[1] of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, has demonstrated hereditary antigenic groups in the sperm cells of mice. Thoroughly washed pooled spermatozoa from the vasa deferentia and epididymides of male mice of the same inbred family were injected intraperitoneally into female mice of a different inbred family. From 7 to 14 days after the 12th to 20th injection, the injected mice were bled. The resulting antiserums were freed from antibodies common to all family groups by absorption on the sperm cells of a third inbred mouse family. Parallel agglutination tests were then made with the resulting reduced antiserums, using motile sperms of the 4 different inbred mouse strains. Agglutination tests were run in the hanging drop, reading, usually being made at the end of from 15 to 30 minutes. In ++++ agglutination practically all sperms were stuck together in mats or clumps. Adhesion was usually by the tails or middle pieces. There was no reduction in motility. Of the 4 reduced antiserums thus far tested, one gave ++++ agglutination sperms of the homologous family, with practically no cross reactions with heterologous sperms. Two of the reduced antiserums, however, gave minor cross-agglutinations. One antiserum was prepared against spermatozoa of a hybrid family. This serum gave +++ reactions with spermatozoa from each of the two ancestral families. The results of these and other tests led Snell to conclude that there are at least two hereditary antigenic sperm groupings in the 4 inbred families thus far tested. The relation between hereditary sperm grouping and hereditary blood groupings has not yet been determined.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCE

1. Snell, George D., Science, 100:272 (Sept. 22) 1944.

INTRACISTERNAL SERUM THERAPY

In tetanus the development of the pathologic process may be prevented by specific antitetanic serum injected subcutaneously prior to the appearance of symptoms. After symptoms develop such antiserum even if given in massive doses intravenously or by lumbar puncture is ineffective in the majority of cases. Soviet military physicians have therefore tried a new method of antitetanic serum therapy, that of injecting the antiserum

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.